TREATMENT SCREENING QUESTIONNAIRE

(DRAFT)

A. LAST NAME _____, FIRST NAME _____, MI ___

B. PRISON ID NUMBER: ....._____

Instructions to the researcher: When the client gives this questionnaire to you, immediately remove this page. Assign a unique arbitrary study number to the questionnaire, and keep the personal identifier information separate from the data at all times.

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A. BACKGROUND INFORMATION

1. How old are you? ..... _____
   YEARS OLD

2. What is your date of birth? ..... _____/_____/_____
   MONTH DAY YEAR

3. What is your race or ethnic background?
   (Circle one of the following)
   1. *African American/Black*
   2. *American Indian*
   3. *Asian/Pacific Islander*
   4. *Mexican American (Hispanic origin)*
   5. *Other Hispanic (specify):* _____
   6. *White (not of Hispanic origin)*
   7. *Other (specify):* _____

4. What is your legal marital status?
   (Circle one of the following)
   1. *Never married*
   2. *Legally married*
   3. *Living as married (including common law marriage)*
   4. *Separated*
   5. *Divorced*
   6. *Widowed*

5. How many years of school have you finished --
   that is, what is the highest grade you completed? ..... _____
   GRADE

6. Have you --
   (Circle "NO" or "YES" for each of the following)

   a. graduated from high school? ..... No Yes

   b. completed a vocational or technical training program? ..... No Yes

   c. Have you completed your GED? ..... No Yes

   d. Are you currently working on your GED
   or any type of vocational/technical training certificate? ..... No Yes

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PART B: SIMPLE SCREENING INSTRUMENT

Directions: The questions that follow are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the questions in terms of your experiences in the last 6 months before you were put in jail or prison.

Circle "NO" if the statement does not describe you, and "YES" if it does describe you during the last 6 months before you were put in jail or prison--

1. Did you used alcohol or other drugs? (Such as wine, beer, hard liquor, pot, coke, heroin or other opiates, uppers, downers, hallucinogens, or inhalants) ..... No Yes

2. Did you feel that you used too much alcohol or other drugs? ..... No Yes

3. Did you try to cut down or quit drinking or using alcohol or other drugs? ..... No Yes

4. Did you go to anyone for help because of your drinking or drug use? (Such as Alcoholics Anonymous, Narcotics Anonymous, Cocaine Anonymous, counselors, or a treatment program) ..... No Yes

5. Did you have any health problems? For example, did you:
   - 5a. Have blackouts or other periods of memory loss? ..... No Yes
   - 5b. Injure your head after drinking or using drugs? ..... No Yes
   - 5c. Have convulsions, delirium tremens ("the DTs")? ..... No Yes
   - 5d. Have hepatitis or other liver problems? ..... No Yes
   - 5e. Feel sick, shaky, or depressed when you stopped? ..... No Yes
   - 5f. Feel "coke bugs" or a crawling feeling under your skin after you stopped using drugs? ..... No Yes
   - 5g. Get injured after drinking or using? ..... No Yes
   - 5h. Use needles to shoot drugs? ..... No Yes

6. Did drinking or other drug use cause problems between you and your family or friends? ..... No Yes

7. Did drinking or other drug use cause problems at school or at work? ..... No Yes

8. Were you arrested or had other legal problems because of your drug use? (Such as bouncing bad checks, driving while intoxicated, theft, or drug possession) ..... No Yes

9. Did you lose your temper or get into arguments or fights while drinking or using drugs? ..... No Yes

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10. Did you need to drink or use drugs more and more to get the effect that you wanted? ..... No Yes

11. Did you spend a lot of time thinking about drinking or trying to get alcohol or other drugs? ..... No Yes

12. When you drank or used drugs were you more likely to do something you wouldn't normally do, such as break the law, sell things that were important to you, or have unprotected sex with someone? ..... No Yes

13. Did you feel bad or guilty about you drinking or drug use? ..... No Yes

The next questions are about your lifetime experiences.

14. Have you ever had a drinking or other drug problem? ..... No Yes

15. Have any of your family members ever had a drinking or a drug problem? ..... No Yes

16. Do you feel that you have a drinking or a drug problem now? ..... No Yes

PART C: PSYCHOLOGICAL INFORMATION

1. Not counting the effects from alcohol or other drug use, have you ever experienced -- **(Circle "NO" or "YES" for each of the following)**

   a. serious depression? ..... No Yes

   b. serious anxiety or tension? ..... No Yes

   c. hallucinations (hearing or seeing things that others thought were imaginary)? ..... No Yes

   d. trouble understanding, concentrating, or remembering? ..... No Yes

   e. trouble controlling violent behavior? ..... No Yes

   f. serious thoughts of suicide? ..... No Yes

   g. attempts at suicide? ..... No Yes

2. Have you taken any prescribed medications for psychological or emotional problems in the last 6 months? ..... No Yes*

   a. ***[IF YES]**: What? _____

3. How many TIMES before now have you ever been treated for psychological or emotional problems? [DO NOT INCLUDE ALCOHOL OR DRUG TREATMENT] ..... _____ # TIMES

(PLEASE CONTINUE TO NEXT PAGE)

4. How many TIMES before now have you ever been in a drug abuse treatment program? [DO NOT INCLUDE TREATMENTS THAT WERE ONLY FOR ALCOHOL PROBLEMS]..... _____ # TIMES

5. How many TIMES have you ever been in any kind of treatment program for drinking or alcohol problems? [DO NOT INCLUDE AA GROUPS]..... _____ # TIMES

PART D: TREATMENT SCALE

Directions: Please circle the answer that best describes you or the way you have been feeling lately.

	STRONGLY DISAGREE	DISAGREE	UNDECIDED	AGREE	STRONGLY AGREE
1. You need help in dealing with your drug use.	SD	D	U	A	SA
2. It is urgent that you find help immediately for your drug use.	SD	D	U	A	SA
3. You are tired of the problems caused by drugs	SD	D	U	A	SA
4. You will give up your friends and hangouts to solve your drug problems	SD	D	U	A	SA
5. You can quit using drugs without any help.	SD	D	U	A	SA
6. Your life has gone out of control	SD	D	U	A	SA
7. You want to get your life straightened out...	SD	D	U	A	SA

PART E: CRIMINAL HISTORY

1. Altogether, how many TIMES have you been convicted of a crime in your life? [THIS MEANS YOU WERE FOUND GUILTY OR PLEAD GUILTY TO A CRIME] ..... _____ # TIMES

2. How many times during your whole life have been in Jail, Prison, or Juvenile Lock-up? ..... _____ # TIMES

3. How old were you the first time you were put in jail, prison, or juvenile lock-up? ..... _____ AGE

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4. Are you currently in jail/prison for theft, auto theft, or forgery? .....No Yes

5. Have you ever had your probation/parole revoked? .....No Yes

5a. Have you ever been put in jail/prison while you were on probation/parole because you had committed a new crime? .....No Yes

6. Have you ever been told that you had a drug or alcohol problem? .....No Yes

7. Have you ever been employed full-time (at least 35 hours per week) for at least 6 months out of the last 2 years? .....No Yes

8. Have you ever been a gang member? .....No Yes

9. Have you ever been in jail/prison for a violent crime like assault, robbery, manslaughter, murder, rape, or for violent threats? .....No Yes

PART F: TCU DDS II

Directions: The questions that follow also are about your use of alcohol and other drugs. Mark the response that best fits for you. Answer the questions in terms of your experiences in the last 12 months before you were put in jail or prison.

Circle "NO" if the statement does not describe you, and "YES" if it does describe you during the last 12 months before you were put in jail or prison--

1. Did you use larger amounts of drugs or use them for a longer time than you had planned or intended?.....No Yes

2. Did you try to cut down on your drug use but were unable to do it? .....No Yes

3. Did you spend a lot of time getting drugs, using them, or recovering from their use?.....No Yes

4. Did you get so high or sick from drugs that it--

   a. kept you from doing work, going to school, or caring for children?.....No Yes

   b. caused and accident or put others in danger? .....No Yes

5. Did you spend a less time at work, school, or with friends so that you could use drugs?.....No Yes

6. Did your drug use cause--

   a. emotional or psychological problems? .....No Yes

   b. problems with friends, family, work, or police?.....No Yes

   c. physical health or medical problems?.....No Yes

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7. Did you increase the amount of a drug you were taking so that you could get the same effects as before? ..... No Yes

8. Did you ever keep taking a drug to avoid withdrawal or keep for getting sick? ..... No Yes

9. Did you get sick or have withdrawal when you quit or missed taking a drug? ..... No Yes

(END OF FORM, THANKS)